ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for the HIPAA Unsolicited 277 Encounter Status Transaction

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Revision History

Date	Version	Description	Author
XX/XX/2003	1.0	Draft document for Unsolicited (U277) Encounter Status Transactions	AHCCCS Information Services Division

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Table of Contents

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Response Transactions
- 278 Prior Authorization Transaction
- 837 and NCPDP Encounter Transactions
- *Unsolicited 277 Encounter Status Transaction*

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both AHCCCS and its providers are HIPAA covered entities.

Document Objective

This Companion Document provides information about the 277 Health Care Payer Unsolicited Claim Status Transactions that is specific to AHCCCS and AHCCCS trading partners. AHCCCS uses the unsolicited version of the 277 Transaction to inform submitting health plans of the statuses of encounters that have been adjudicated by AHCCCS. For this transaction, the document describes the data sent electronically to AHCCCS health plans and other trading partners in response to encounter submissions.

Intended Users

Companion Documents are intended for the technical staff of the external entities who are responsible for electronic transaction/file exchanges.

Relationship to HIPAA Implementation Guides

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the AHCCCS environment and interchange conventions for batch Unsolicited 277 (U277) Encounter Status Transactions. It also provides trading partners with specific information on the fields and values on U277 transactions received from AHCCCS.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

The Unsolicited Encounter/Claim Status Transaction differs from other X12 and NCPDP Transactions in that it is not yet mandated by HIPAA Transaction and Code Set Rules. Rather, it is an X12 Transaction that AHCCCS uses to support implementation of 837 and NCPDP Transactions for encounters by returning information to health plans on encounters accepted and adjudicated by AHCCCS.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, AHCCCS, the AHCCCS Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Data interchange conventions applicable to the transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides more specific information relating to the transaction included in this Companion Document including: ▪ A statement of the purpose of transaction specifications for electronic interchanges between AHCCCS and other HIPAA covered entities. ▪ Detailed specifications that show how AHCCCS expects to populate data elements in the Unsolicited 277 Encounter Status Transactions when AHCCCS uses transaction data elements in ways that are not fully described by the HIPAA Implementation Guide.

2. Unsolicited 277 Encounter Status Transactions

2.1 Transaction Overview

Encounter Status Transactions

AHCCCS uses the ASC X12 277 Health Care Payer Unsolicited Claim Status Transaction to inform contracted health plans of the statuses of the encounters that they have submitted to AHCCCS. Encounter that have been accepted by AHCCCS and adjudicated by the AHCCCS Pre-Paid Medical Management Information System (PMMIS) are reported on the Unsolicited 277 Transaction. Encounters that have been pended or denied by PMMIS as well as approved encounters are included.

The structure and content of the U277 Transaction are similar to those of the 277 Claim Status Response Transaction that AHCCCS sends in response to 276 Claim Status Requests from providers for fee-for-service claims. There are, however, some major variations:

- Unsolicited 277 Transactions are transmitted without 276 Requests.
- The Unsolicited 277 Transaction has a separate ASC X12 Implementation Guide from the 277 Response Transaction with variations in data requirements.
- Additional variations in use of 277 data structures reflect differences between AHCCCS claim and encounter data.

Following periodic PMMIS batch encounter adjudication, AHCCCS returns to each plan a U277 Status Transaction with information on each adjudicated encounter. U277 Transactions can be downloaded to health plan systems as HIPAA compliant transactions. In either mode, claim status responses carry identification and status information as well as service data. HIPAA Status Category and Status Codes to tell U277 receivers when encounters are approved or denied by AHCCCS and when they are pended for correction and require modification. For each health plan, encounters are in 277 sequence by Servicing Provider ID, AHCCCS Recipient ID, and Encounter Reference Number.

As a result of some AHCCCS MCOs (Managed Care Organizations) desiring additional data not found in U277, AHCCCS created a U277 Supplemental File.

As is noted below, the Unsolicited 277 Encounter Status Transaction replaced the pre-HIPAA Adjudicated Encounter File. AHCCCS encounter correction procedures remain as is and are not affected by the U277.

Files Replaced or Impacted

Unsolicited 277 Encounter Status Transaction

Replaced Files
Pre-HIPAA Adjudicated Encounter File

Impacted Files
None

2.2 Unsolicited 277 Encounter Status Transaction

Standard Implementation Guide

The standard Implementation Guide for the 277 Transaction Set is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N Implementation Guide for the Health Care Payer Unsolicited Claim Status Transactions. The Implementation Guide for the U277 is not yet final. The version adopted by AHCCCS and used in preparation of this document is:

- ASC X12N 277 (003070X070) dated May 2003

An Addenda to this Guide has not been published. AHCCCS MCOs may either purchase the U277 Implementation Guide or rely on AHCCCS specifications.

Unsolicited 277 Transaction

For each health plan that receives them, U277 Encounter Status Transactions are organized in a hierarchical manner by servicing provider, health plan member, encounter, and service line. A 2000D Claim Submitter Level Loop appears for each member and a 2200D Claim Submitter Trace Number Loop for each encounter. Each 2000D Loop and loops subservient to it carry recipient identification and demographic information and claim status, service, and payment information.

The combinations of HIPAA compliant Status Category and Status Codes that AHCCCS uses on the U277 reflect encounter processing categories determined by PMMIS. Complete translation of PMMIS encounter error codes is not attempted. To give encounter submitters data not provided on the 277 Transaction, AHCCCS creates a U277 Supplemental File to accompany U277 Transactions. Refer to Section 4.4, U277 Supplemental File, for more information.

Further information on the Status Category and Status Codes used by AHCCCS in the U277 Transaction can be found in Section 5.2, Unsolicited 277 Encounter Status Transaction Specifications.

Related Transactions	The Unsolicited 277 Encounter Status Transaction is similar in design and data content to the response component of the 276/277 Claim Status Request and Response Transaction Set. As used by AHCCCS, however, the U277 is quite distinct and serves as a separate business function. It transmits data on encounters to health plans rather than data on fee-for-service claims to providers.
Transmission Schedules	U277 files will be available from the AHCCCS FTP server following encounter processing.

3. Technical Infrastructure and Procedures

AHCCCS Data Center Communications Requirements

Trading partners connect to AHCCCS by going from the Internet through a Virtual Private Network (VPN) Tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Software to establish provider computers as VPN Clients is available from the sources documented in the AHCCCS Electronic Claim Submission and Electronic Remittance Advice Requirements document. Detailed information on FTP and VPN setups also appears in that manual.

Technical Assistance and Help

The AHCCCS Information Services Division (ISD) Customer Support Center provides technical assistance related questions about electronic data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (setup, procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

4. Transaction Standards

4.1 General Information

HIPAA Requirements	HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. The U277 has not yet been mandated, however, AHCCCS has adopted the standard transaction as it is expected to be mandated in the future.
Size of Transmissions/ Batches	The U277 Implementation Guide makes no recommendations as to the maximum transaction size.
Other Standards	Use of U277 Header and Service Line Data for Various Encounter Types Variations between use of 2200D (Header) and 2220D (Service Line) Loops for institutional and non-institutional encounter types are a major consideration for the U277 Transaction. All institutional encounters, both inpatient and outpatient, use a single header-level 2200D Loop. Line level data on institutional encounters is not included on the U277. For non-institutional encounters (Professional, Dental, and Pharmacy), both header and line data (2200D and 2220D Loops) appears for every service line.

4.2 Batch Data Interchange Conventions

Overview of Data Interchange

When sending batch U277 Transactions to encounter submitters, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All U277 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides.

Transaction Specifications that say how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes appear in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Sender and Receiver Identification Numbers in ISA and GS Segments are assigned in Trading Partner Tables maintained by AHCCCS.

Envelope Specifications Table

Definitions of table column follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
The data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number (866004791)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		The six-character Health Plan Id assigned by AHCCCS.
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00307	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	1	Interchange Acknowledgement Requested AHCCCS does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the AHCCCS translator will receive them and notify AHCCCS staff of their receipt.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions:

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”) Element Delimiter - “{“ (left rounded bracket – hexadecimal value X”7B”) Composite Component Delimiter (ISA16) - “|” (pipe – hexadecimal value X”7C”) These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HN	Health Care Claim Status Notification (277)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		The six-character Health Plan ID assigned by AHCCCS followed by the three-character Transmission Submitter Number (TSN) and one-character Input Mode.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		003070X070 The U277 Transaction has no Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

Interchange Flows and Acknowledgments	**Please bare with us; this section under construction.**

5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the data elements and code set values that pass between AHCCCS and its trading partners. In some cases the values specified are subsets of the data element values listed or referenced in Implementation Guides. In others, they are specific to AHCCCS requirements.

For example, in the Subscriber Number Loop of a transaction in the Implementation Guide, Element NM109 is defined as an alphanumeric identification element that is between 1 and 30 characters long. In the Transaction Specifications, NM109 is defined as the member's AHCCCS ID. The length and format of the field are based on the characteristics of the AHCCCS Recipient ID rather than on the variable field size defined for the transaction by the more generic Implementation Guide.

Relationship to HIPAA Implementation Guides

Transaction Specifications supplement information in the Implementation Guides for each HIPAA Transaction with additional information specific to the trading partners using the transaction. Although the Unsolicited 277 Transaction is not yet mandated, it is likely to be mandated in the future. AHCCCS has taken the same approach to its data requirements as it has for mandated transactions.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 U277 Encounter Status Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify and describe the data elements used in the AHCCCS U277 Encounter Status Transaction. These elements tell encounter submitters the results of the periodic AHCCCS encounter adjudication process. Approved, pended and denied encounters are included.

A U277 Supplemental File accompanies the U277 Transaction for encounter submitters that request it. The Supplemental File carries encounter status data that is not support by the U277, including, for encounters denied by AHCCCS, the detailed Denial Reason Codes generated by PMMIS> More information can be found in Section 4.4, U277 Supplemental File.

Status Category and Status Codes

The U277 Transaction uses HIPAA compliant Health Care Claim Status Category and Health Care Claim Status Codes to show the statuses of selected encounters and service lines. For institutional encounters, statuses are reported at the invoice level. Professional, dental, and pharmacy statuses are reported at the service level line.

On the U277 Transaction, institutional encounters populate data in only the header-level 2200D Loop without use of the 2220D Service Line Loop. Professional, dental, and pharmacy encounters are "split" when they have more than one payment line. They are represented on the U277 by data in both 2200D and 2220D Loops with a separate header for each service line.

AHCCCS assigns four sets of Status Category/Status Code combinations at the institutional invoice or professional/dental/pharmacy service line level. Detailed information appears in the table below.

For each institutional invoice or professional/dental/pharmacy service line submitted during the previous month and accepted by AHCCCS, the system generates an appropriate HIPAA compliant Status Category/Status Code combination for the U277 Transaction.

STATUS CODES USED BY AHCCCS ON THE 277 ENCOUNTER STATUS TRANSACTION		
PMMIS Status	**277 Status Category Code**	**277 Status Code**
AP – Adjudicated/Approved	FO – Finalized – The claim/encounter has completed the adjudication cycle and not more action will be taken.	107 – Processed according to contract/plan provisions.
PE – Pended	P1 – Pending/In Process – The claim or encounter is in the adjudication system.	21 – Missing or invalid information.
DN – Auto Deny	F2 – Finalized/Denial – The claim/line	107 – Processed according to

STATUS CODES USED BY AHCCCS ON THE 277 ENCOUNTER STATUS TRANSACTION		
PMMIS Status	**277 Status Category Code**	**277 Status Code**
	has been denied.	contract/plan provisions.
DE – Voluntary Plan Deletion	F3 – Finalized/Revised – Adjudication information has been changed.	0 – Cannot provide further status electronically.

Transaction Specifications Table

U277 Encounter Status Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	277	Health Care Claim Status Notification
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		A number assigned by AHCCCS that is unique within the functional group (GS/GE) and interchange (ISA/ISE) envelopes
N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	00010	Information Source, Information Receiver, Provider of Service, Subscriber, Dependant
N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	08	Status
N/A	BHT	BHT03	Originator Application Transaction Identifier	An identification number that identifies a transaction within the originator's applications system		A unique number generated by AHCCCS to identify the U277 Transaction that is different from the number assigned to all other U277 Transactions. For the U277 Transaction, BHT03 consists of the Health Plan ID (X[6]), the TSN (X[3]), Date (CCYYMMDD), and a Transaction Sequence Number (N[3]).
N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the U277 Transaction is created in CCYYMMDD format.
N/A	BHT	BHT06	Transaction Type Code	Code specifying the type of transaction	TH	Receipt Acknowledgement Advice
2000A	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	1	Always "1" for the initial HL Segment
2000A	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	20	Information Source
2000A	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The organization name of the payer
2100A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer's Identification Number
2100A	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Federal Tax ID
2000B	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	2	The HL Segment within the 2000B Information Receiver Level Loop is always for the second HL Segment in the transaction.
2000B	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	1	The level of the HL Segment to which this HL Segment is subordinate.
2000B	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	21	Information Receiver
2000B	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	41	Submitter
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100B	NM1	NM103	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		For AHCCCS, the information receiver is an organization with a single name. NM103 in this loop is an organization name for the receiving health plan.
2100B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100B	NM1	NM109	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query		The six-digit AHCCCS Health Plan ID, the three-digit Transmission Submitter Number (TSN).
2000C	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	3 - nnn	For AHCCCS, this is the third, servicing provider level HL Level within the U277 Transaction. For U277 Transactions, with any number of servicing providers within a health plan network, the value of HL01 in Loop 2000C beings with 3 and increases by 1 for each servicing provider. The second servicing provider should have a 2000C/HL01 value of 4, the third a value of 5, and so forth.
2000C	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	2	For AHCCCS, the 2000C Service Provider Level Loop is always subordinate to the 2000B Information Receiver Loop.
2000C	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	19	Provider of Service
2000C	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional Subordinate Data Segment in the Hierarchical Structure
2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	1P	Provider
2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100C	NM1	NM103	Provider Last or Organization Name	The last name of the provider of care or name of the provider organization submitting a transaction or related to the information provided in or request by the transaction		The name of the encounter's servicing provider.
2100C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	SV	Service Provider Number

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100C	NM1	NM109	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		The six-character AHCCCS Provider ID and two-character Location Code of the servicing provider on the encounter.
2000D	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	4 - nnn	For AHCCCS, this is the final HL Level within the U277 Transaction. For interactive requests, HL01 in the 2000D Loop will always have a value of 4. U277 Transactions can have any number of recipient claim status requests, the value of HL01 in Loop 2000D begins with 4 and increases by 1.
2000D	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	3	For AHCCCS, the 2000D Subscriber Loop is always subordinate to the 2000C Service Provider Loop.
2000D	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	22	Subscriber
2000D	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	0	No subordinate HL Segment in this hierarchical structure A subordinate segment would be at the dependent level – not used by AHCCCS.
2100D	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100D	NM1	NM103	Subscriber Last Name	The surname of the insured individual or subscriber to the coverage		The patient's Last Name
2100D	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		The patient's First Name
2100D	NM1	NM105	Subscriber Middle Name	The middle name of the subscriber to the indicated coverage or policy		The patient's Middle Name or Initial
2100D	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MI	Member Identification Number

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100D	NM1	NM109	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		The recipient's AHCCCS ID
2200D	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	1	Referenced Transaction Trace Numbers The 2200D Loop, although it is called the "C Submitter's Identifier Loop" in the U277 Implementation Guide, is the loop that carrier header-level data for both institutional and non-institutional encounters. AHCCCS populates a single 2200D Loop for each encounter.
2200D	TRN	TRN02	Trace Number	Identification number used by originator of the transaction		Patient Account Number matches CLM01 from all 837 Transactions.
2200D	STC	STC01-1	Health Care Claim Status Category Code	Code indicating the category of the associated claim status code		Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2200D	STC	STC01-2	Health Care Claim Status Code	Code conveying the status of a claim		Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2200D	STC	STC02	Status Information Effective Date	The date that the status information provided is effective		The AHCCCS Encounter Processing Date in CCYYMMDD format
2200D	STC	STC03	Action Code	Code indicating type of action	NA	No Action Required Actions taken to correct pended encounters are separate from the U277 Transaction. Health plans receive separate Pended Encounter Files to facilitate encounter correction.
2200D	STC	STC04	Total Claim Charge Amount	The sum of all charges included within this claim		The amount charged by the provider for all services on the claim that generated this encounter.
2200D	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1K	Payer's Claim Number

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2200D	REF	REF02	Payer Claim Control Number	A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)		This REF Segment carries the 14-digit Claim Reference number assigned by AHCCCS.
2200D	REF	REF01	Reference Identification Qualifier	Code qualifying the specific type of bill or claim	BLT	Billing Type This REF Segment is used on institutional claims only
2200D	REF	REF02	Bill Type Identifier	A code indicating the specific type of bill or claim		The Institutional claim's UB-92 Type of Bill Code
2200D	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	EA	Medical Record Identification Number
2200D	REF	REF02	Medical Record Number	A unique number assigned to patient by the provider to assist in retrieval of medical records		When available, the Medical Record Number with which the claim used by the health plan to generate an encounter is associated.
2200D	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service
2200D	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates expressed in format CCYYMMDDCCYYMMDD
2200D	DTP	DTP03	Date Time Period	Expression of a date. A time. Or range of dates, times or dates and times		On institutional encounters, the first and last Dates of Service. Dates of Service appear only at the service line level for professional, dental, and pharmacy encounters.
2220D	SVC	SVC01-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	AD HC ND	American Dental Association Codes Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes National Drug Code The "AD" value is for dental service lines, the "HC" value for professional service lines, and the "ND" value for pharmacy service lines.

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D	SVC	SVC01-2	Service Identification Code	A code from a recognized coding scheme identified by a qualifier that describes the service rendered		On dental encounter lines, the ADA Procedure Code. On professional and outpatient lines, the HCPCS Procedure Code. On pharmacy lines, the NDC Code.
2220D	SVC	SVC01-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the first Procedure Modifier on a professional service line.
2220D	SVC	SVC01-4	Procedure Modifier	This identifies special circumstances related to the performance of the service.		If present, the second Procedure Modifier on a professional service line.
2220D	SVC	SVC01-5	Procedure Modifier	This identifies special circumstances related to the performance of the service.		If present, the third Procedure Modifier on a professional service line.
2220D	SVC	SVC01-6	Procedure Modifier	This identifies special circumstances related to the performance of a service		If present, the fourth Procedure Modifier on a professional service line.
2220D	SVC	SVC02	Line Item Charge Amount	Charges related to this service		For professional, dental, and pharmacy service lines, the amount charged by the provider for the service.
2220D	SVC	SVC03	Line Item Charge Amount	The actual amount paid to the provider for this service line		For professional, dental, and pharmacy service lines, the amount paid by the health plan for the service.
2220D	SVC	SVC07	Quantity	Numeric value of quantity		The Units of Service for the service line.
2220D	STC	STC01-1	Health Care Claim Status Category Code	Code indicating the category of the associated claim status code		An STC01-1 value is generated, in combination with a value for STC01-2, for every professional, dental, or pharmacy service line reported on a U277 Transaction. Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section. For institutional encounters, Status Codes appear in the encounter level 2200D Loop.

U277 ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D	STC	STC01-2	Health Care Claim Status Code	Code conveying the status of a claim		AN STC01-2 value is generated, in combination with a value for STC01-1, for every professional, dental, or pharmacy service line reported on a U277 Transaction. Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2220D	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	FJ	Line Item Control Number
2220D	REF	REF02	Line Item Control Number	Identifier assigned by the submitter/provider to this line item		The AHCCCS Claim Reference Number (CRN) Suffix assigned to the service line.
2220D	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service
2220D	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	A range of line item Service Dates in CCYYMMDDCCYYMMDD format. Both from and through dates are included even when they are the same.
2220D	DTP	DTP03	Service Line Date	Date of service of the identified service line on the claim		Service line Begin and End Dates of Service for non-institutional encounters
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		The number of segments in the transaction, including ST and SE segments.
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		The same control number that appears in ST02.

6. U277 Supplemental File

Supplemental File Summary

AHCCCS generates the U277 Supplemental File in conjunction with U277 Transactions. The Supplemental File supplies encounter data not carried by the U277 Transaction, including the Encounter Denial Codes generated by PMMIS. Pended encounters are handled separately by the AHCCCS Encounter Pend Correction Process and Pend Codes are not necessary in this context. The Supplemental File is available to U277 receivers that request it from AHCCCS.

In terms of claim level and line level information, the Supplemental File follows the structure of the AHCCCS 277 Transaction. Encounters are represented as header-level segments for institutional encounters and as single services with both header and line segments for professional, dental, and pharmacy encounters.

The U277 Supplemental File is a fixed-length sequential file with **nnn**-byte records. It is more similar in structure to pre-HIPAA AHCCCS interface files than to the U277 Transaction. It has three record types:

- A single Header Record with identification information on the payer (AHCCCS) and the information receiver (the AHCCCS health plan)
- Multiple Encounter Records with supplemental data elements for each institutional encounter or non-institutional service line
- A single Trailer Record with identifiers and a control count

Data element level information on the U277 Supplemental File appears in the remainder of this section.

U277 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
HEADER RECORD – 1 record per U277 Transaction				
Header	Contractor ID	The Health Plan ID assigned by AHCCCS	6AN	
Header	Transmission Submitter Number (TSN)	A number assigned by AHCCCS to submitters of electronic transactions	3AN	
Header	Input Mode	The kind of data in the encounter	1AN	
Header	Process Date	The date on which the Supplemental File is created	8AN	Format is CCYYMMDD.
Header	File Type Code		2AN	Value is “AE” for Adjudicated Encounter
Header	Record Type		2AN	Value is “T0”
ENCOUNTER RECORD – 1 or more records per U277 Transaction				
Encounter	AHCCCS CRN	The Claim Reference Number assigned to the encounter by AHCCCS	14AN	For institutional encounters reported at the invoice level, the final two CRN positions are “00”. For non-institutional encounters, reporting is by service line and the final two positions have a value of from “01” to “50”.
Encounter	Health Plan CRN	The Claim Reference Number assigned by the Health Plan	30AN	MCO CRN should be 30 characters.
Encounter	Form Type		1AN	Form Type identifies the form type assigned by AHCCCS during processing.
Encounter	RI Number	Reinsurance Claim Number	10/AN	
Encounter	Primary Diagnosis	The Primary or Principal Diagnosis Code for the institutional invoice or non-institutional service line	6AN	Primary diagnosis is the diagnosis identified as primary on the claim/encounter.
Encounter	Category of Service	The AHCCCS Category of Service assigned to the encounter	2AN	Category of Service is assigned to the encounter at the line level for all but institutional encounters.
Encounter	CRN **(???)** Category	The HIPAA Status Category Code assigned to the encounter or service line	2AN	
Encounter	CRN **(???)** Status Code	The HIPAA Status Code assigned to the encounter of service line	3AN	
Encounter	PMMIS Status	A mnemonic for the status assigned to the encounter or service line by PMMIS	2AN	“AP” = Adjudicated/Approved “DE” = Voluntary Plan Delete “DN” = Auto Deny “PE” = Pended

U277 SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
Encounter	PMMIS Denial Reason	The PMMIS Denial Reason Code or Codes on denied encounters and service lines		
Encounter	Status Effective Date	The date on which the encounter or service line was adjudicated and assigned a PMMIS Status	8N	CCYYMMDD format
Encounter	Record Type		2AN	Value is “C1”
TRAILER RECORD – 1 record per U277 Transaction				
Trailer	Transmission Submitter Number (TSN)	The number assigned to the transaction submitter by AHCCCS	3AN	
Trailer	Current Year		2N	YY format
Trailer	Current Julian Date		3N	DDD format
Trailer	File Type Code		AE	Adjudicated Encounter
Trailer	# of Records on File		6N	
Trailer	Record Type		T9	